February 17, 2017

The Honorable Edward J. Kasemeyer
Chair
Senate Budget & Taxation Committee
3 West Miller Senate Office Bldg.
Annapolis, MD  21401-1991

The Honorable Maggie McIntosh
Chair
House Appropriations Committee
121 House Office Bldg.
Annapolis, MD  21401-1991

Re:    **2016 Joint Chairmen's Report (p. 76) – Independent Review on the Organization of Eligibility Entry Points for Health and Social Services**

Dear Chairmen Kasemeyer and McIntosh:

In keeping with the requirements of the 2016 Joint Chairmen's Report (p. 76), enclosed is the independent review on the organization of eligibility entry points for health and social services. Manatt Health Solutions, the firm that conducted the independent review, was selected through a competitive procurement issued by the University of Maryland-Baltimore County.  The review of the organization of eligibility entry points for health and social services in other states was conducted to serve as a potential model for Maryland in order to (1) maximize access to those services; (2) reduce duplication, inefficiency and costs; and (3) maximize federal fund participation.  DHMH, along with the Department of Human Resources, the Maryland Health Benefit Exchange and the Department of Budget Management have reviewed the report.

Thank you for your consideration of this information.  If you have questions or need more information on the subjects included in this report, please contact Webster Ye, Director of Governmental Affairs at (410) 767-6480.

Sincerely,

Dennis R. Schrader
Secretary

Enclosure

cc:    Shannon McMahon        Debbie Ruppert
       Tricia Roddy                   Alyssa Brown
       Susan Tucker                  Webster Ye

# Review of the Organization of Entry Points for Publicly Funded Health and Social Services in Maryland

December 2016

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## Executive Summary

Required by the 2016 Chairmen's Report on the Fiscal 2017 State Operating Budget (SB 190) and the State Capital Budget (SB 191) and Related Recommendations, this report 1) provides an overview of current "entry points" into health and social service programs in Maryland, focusing primarily on Medicaid and Marketplace coverage; 2) describes promising approaches being adopted in other states for providing efficient, coordinated access to health coverage and social service programs; and 3) offers recommendations for improving access to health coverage programs in Maryland and reducing inefficiencies.

### *Inventory of Current Entry Points*

Maryland residents can apply for health coverage and social service programs through a broad number of "entry points," including online websites operated by the Maryland Health Benefit Exchange (MHBE) and Department of Human Resources (DHR), by contacting a call center, or by receiving assistance from local health department staff, local department of social services staff, Navigators, certified application counselors, hospitals, or insurance brokers. The wide array of entry points gives consumers many different opportunities to apply for and renew coverage, and allows them to select an approach consistent with their personal circumstances and needs. Of particular note, Maryland has established a single, unified system to conduct eligibility determinations for Marketplace coverage and most forms of Medicaid eligibility and also established "myDHR," an online portal for applying for social service programs and Medicaid coverage. These efforts contribute to a smoother enrollment experience for Maryland consumers. At the same time, Maryland families still often must work with multiple entry points if they happen to have members who qualify for coverage on different grounds or certainly if they require both health care and social services. This imposes an administrative burden on Maryland residents, and, as importantly, may result in the state expending unnecessary resources to gather and verify information on multiple occasions from the same applicant.

### *Best Practices*

As in Maryland, states around the country are taking a new look at how best to improve and coordinate enrollment into health and social service programs. This report draws on the published literature on this topic and interviews with officials in Colorado, Idaho, New York, and Michigan to identify emerging best practices. These best practices include changes to a state's organizational structure and culture; targeted efforts to align health and social service program policies; improving business processes; strengthening integration of IT systems and the sharing of data; and using data to monitor and improve coordination and effective enrollment on an ongoing basis.

## *Recommendations*

Based on the analysis of Maryland entry points and emerging best practices in other states, the report identifies a series of recommendations for Maryland to consider for further improving the efficiency and effectiveness of the state's entry points to health coverage programs. Some of the recommended efforts already are under active consideration or slated to occur, while others may require a significantly longer timeline for implementation. Although the report sought to identify actionable recommendations based on experiences in other states, it should be noted that improving entry points and the consumer experience often requires relatively complex changes to staffing patterns, workflow processes, organizational culture, and/or IT systems. The recommendations are as follows:

| Recommendation | Description |
|---|---|
| 1. **Establish a working group on coordination of health and social service programs.** | The working group should be dedicated to sustaining and strengthening cross-agency collaboration on improving coordination across health and social service programs. It should build on and leverage existing coordination efforts and should facilitate cross-agency participation. |
| 2. **Establish key performance metrics on access to health and social service programs and provide for public reporting.** | The metrics should include basic data on applications, renewals, and use of various entry points for health and social service programs, but also measures that capture the effectiveness of coordination across programs. |
| 3. **Establish a seamless approach to evaluating an individual for all forms of Medicaid eligibility (i.e., both MAGI and non-MAGI Medicaid).** | Maryland should work toward a seamless eligibility and enrollment experience for individuals seeking both MAGI and non-MAGI Medicaid, minimizing the need for "handoffs" between systems and consumer assistance workers. |
| 4. **Create a data platform to facilitate data exchange between health and social service programs.** | As the Department of Human Resources already is considering with its "MD THINK" initiative, the state should pursue a shared data platform that can facilitate the sharing of information across health and social service programs. |
| 5. **Create automatic eligibility linkage between TANF/SNAP and Medicaid.** | As the Department of Human Resources already is considering with its "MD THINK" initiative, use the option available under federal law to automatically provide Medicaid to TANF and selected SNAP recipients, eliminating the need for them to undergo a separate determination of eligibility for health coverage. |

| Recommendation | Description |
|---|---|
| 6. **Review the roles of eligibility workers and other assisters to provide a seamless experience to consumers.** | Conduct an assessment of the role of Navigators and eligibility workers in all agencies to determine if their responsibilities could be modified or expanded to provide consumers with a more seamless experience that allows them to apply for coverage, receive an eligibility determination, and enroll in a specific plan during a single session. |
| 7. **Provide Medicaid beneficiaries with the ability to select a Medicaid managed care plan through the Maryland Health Connection (MHC).** | Implement current plans to modify the MHC to allow consumers found eligible for Medicaid to select their managed care plan, eliminating an unnecessary delay in initiation of managed coverage. |
| 8. **Systematically build referrals and "warm handoffs" between DHR, DHMH, and MHBE.** | Conduct a review of how to improve "handoffs" when consumers must be referred to a different agency, systematically identifying when and how such referrals should be conducted. |
| 9. **Establish integrated "back end" systems for customer relationship management and documentation storage for health coverage programs.** | Establish an integrated customer relationship management system for health coverage programs that can be used by Navigators, call center staff, local health departments, and local departments of social services so that they can provide coordinated service to consumers, as well as an integrated system for storing documentation and other eligibility information for health programs. This type of common infrastructure is one of the primary goals of the MD THINK initiative |

# Review of the Organization of Entry Points for Publicly Funded Health and Social Services in Maryland

## I. Purpose

Pursuant to requirements in the 2016 Chairmen's Report on the Fiscal 2017 State Operating Budget (SB 190) and the State Capital Budget (SB 191) and Related Recommendations, this report provides an independent review of the organization of eligibility determination entry points for publicly-funded health coverage and social service programs in Maryland and other states. The review is intended to identify potential models that can inform deliberations in Maryland regarding the development of improved entry point systems and processes that will 1) maximize access to publicly-funded health and social services in Maryland, focusing primarily on Medicaid and Marketplace coverage; 2) reduce duplication, inefficiency, and costs; and 3) maximize federal fund participation.

## II. Scope of Report

The report provides a review of current entry points into health and social service programs and recommendations for improving Maryland's approach. It is focused on entry points for Medicaid, the Children's Health Insurance Program (known as the Maryland Children's Health Insurance Program or "MCHP" in Maryland), and Marketplace coverage. Secondarily, it also assesses the intersection between health coverage programs and other social services, such as the Supplemental Nutrition Assistance Program (called the Food Supplement Program, or FSP, in Maryland) and the Temporary Assistance to Needy Families (called Temporary Cash Assistance, or TCA, in Maryland).

**First, the report presents an inventory of Maryland's current "entry points"** – or, the avenues available to Maryland residents to apply for and enroll in a health coverage program and social service programs. These include state agency websites where individuals can submit applications, call centers that can take applications by phone, and local health departments and local departments of social services where applicants can receive in-person assistance. The analysis also provides data on the staffing and eligibility and enrollment expenditures of the Department of Health and Mental Hygiene (DHMH), the Department of Human Resources (DHR), and the Maryland Health Benefit Exchange (MHBE), the three major agencies charged with connecting people to health coverage.[1]

**Second, the report describes promising approaches being adopted in other states for providing efficient, coordinated access to health coverage and social service programs**. The promising practices are based on a literature review, as well as interviews with Colorado, Idaho, New York, and Michigan, each of which to varying degrees has taken steps to improve the

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[1] MHBE was established as a public corporation and an independent unit of State government to operate the state's health benefit exchange marketplace under the ACA. For the purposes of this report, we refer to the MHBE as a state agency.

organization of entry points for health coverage and social service programs.

**Finally, the report offers recommendations for improving access to health coverage programs in Maryland, reducing inefficiencies, and maximizing federal funding participation.** The recommendations offer a range of potential options to Maryland decision-makers from fundamental, sweeping reform to more discrete policy and process changes that could improve the efficiency of Maryland's eligibility and enrollment entry points.

It should be noted that the bulk of the research for this report was conducted prior to the elections held on November 8, 2016, which have introduced a new element of uncertainty into the future of the federal government's approach to financing Medicaid, Marketplaces,

> **Box 1: Definition of Key Terms**
> Throughout this report, "Medicaid" is used to encompass low-income children, parents, pregnant women, and adults without disabilities who qualify for Medicaid or MCHP under "Modified Adjusted Gross Income" or "MAGI" rules, as well as seniors, people with disabilities, foster care children, and others who qualify under "non-MAGI" rules. The report uses "Marketplace coverage" to refer to the Qualified Health Plans offered through the Maryland Health Benefit Exchange and, for those who qualify, to the Advance Premium Tax Credit (APTC) and Cost-Sharing Reductions (CSR) used to make such coverage more affordable.

and potentially other social service programs. As the new President and Congress establish and implement their agenda, it will be important for Maryland policymakers to monitor those developments, and to assess their implications for federal financing of some of the changes recommended in this analysis.

## III. Methodology

The research for this analysis was conducted between October 7, 2016 and November 15, 2016 and consisted of a literature review on promising practices for improving access to and coordination of health and social service programs; a detailed review of the current "as is" state of Maryland's entry points based on structured data collection tools and interviews with agency leadership; and semi-structured interviews with state officials in Colorado, Idaho, Michigan and New York. Appendix A provides a more detailed description of the methodology used for each component of the research, along with a complete list of interviewees. Appendix C lists the major secondary sources identified during the literature review, including those referenced in this report.

## IV. Inventory of Maryland's Entry Points

To provide context for the discussion of best practices in other states and related recommendations, this section provides an inventory of Maryland's current entry points to health and social service programs. Organized by agency, this review includes a discussion of eligibility and enrollment processes, IT systems and personnel, and coordination for each entry

point. While each entry point is described separately, it is important to note that many consumers rely on multiple sources of information and support when applying for and renewing coverage. For example, a consumer might initiate an application on the phone through the MHBE website, but then visit a local health department for in-person assistance if she or he runs into challenges.

## *Background and Context*

Maryland's approach to entry points for health and social services has been reconfigured in recent years, largely in response to the Affordable Care Act (ACA).[2] The ACA includes numerous provisions aimed at establishing simple, coordinated application and enrollment procedures for health care coverage. The law requires states to allow people to apply for Medicaid, CHIP and Marketplace coverage by telephone, mail, in-person, online or through other available electronic means;[3] to adopt a "no wrong door" policy that ensures that – no matter the entry point through which an individual initiates the eligibility determination process – applicants end up enrolled in the appropriate health coverage program based on their income and other eligibility criteria;[4] and to offer people a single streamlined application for all health coverage programs. Notably, the "no wrong door" and single, streamlined application requirements of the ACA do *not* extend to social service programs. States can elect to coordinate their health coverage and social services programs, but they are not mandated to do so under federal law.

In light of the requirements described above, Maryland launched a major realignment of how it evaluates eligibility for health and social service programs after passage of the ACA. It elected to establish its own State-Based Marketplace, the MHBE, which could evaluate eligibility not only for Marketplace coverage, but also for MAGI Medicaid. Historically, nearly all Medicaid determinations had been conducted on behalf of the Medicaid agency by DHR, using its eligibility system known as the Client Automated Resources Eligibility System (CARES). DHR continues to evaluate eligibility for most non-MAGI eligibility categories, as well as for FSP, TCA and other social service programs, but it no longer bears primary responsibility for MAGI Medicaid determinations. Table 1 compares application volume across the Marketplace, DHR and DHMH. Appendix B describes in greater detail the specific roles of each Maryland agency that provide eligibility determinations for health coverage and social service programs in the state, as well as related eligibility and enrollment expenditures.

Although social service programs have received less attention from Congress in recent years, it is important to note that the United States Department of Agriculture (USDA) under the Obama Administration has established new options for states to improve access to SNAP and other social service benefits. These include options for states to ensure ease of access, including

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[2] Although it was beyond the scope of this analysis to explore the results of the recent elections for health coverage programs, it is important to note that some or even all of these requirements could be rescinded in the effort to repeal key provisions of the ACA.

[3] 42 CFR 435.907(a)

[4] Section 2201 of the Patient Protection and Affordable Care Act, P.L. 111-148, as amended.

telephone interviews,[5] waivers granting longer eligibility timelines for specific high-need groups (e.g., elderly), mail-in applications[6] and declaratory household expenses. Of note, Maryland recently received federal approval to conduct an Elderly Simplified Application Project (ESAP),[7] which was implemented statewide on November 1, 2016. This approval allows DHR to waive the recertification interview for SNAP, extend the certification period to 36 months, and rely more heavily on computer verification of components of eligibility. Additionally, as discussed more below, DHR has made strides in single applications through implementation of myDHR, allowing customers to establish accounts to apply for and manage benefits, check the status of their applications, and submit updates to their household information.[8] DHR also already has plans to establish the capacity for customers to upload their documents using a smartphone camera in support of their applications.

| Table 1: Average Monthly Applications for Health Coverage and Other Human Service Programs | | | |
|---|---|---|---|
| | MHC[1] | DHR[2] | DHMH[3] |
| Total Medicaid[4] | 73,200[5] | 12,000[6] | 7,000[7] |
| Marketplace Coverage | 12,200[8] | 0 | 0 |
| Other Social Service Programs[9] | 0 | 69,800 | 0 |
| Total | 85,400 | 81,800 | 7,000 |
| [1] Based on average monthly enrollment between February 1, 2015 and January 31, 2016 | | | |
| [2] Based on average monthly enrollment between February 1, 2015 and February 29, 2016 | | | |
| [3] Based on average monthly enrollment between January 1, 2016 and August 31, 2016 | | | |
| [4] "Medicaid" applications may include MAGI, Non-MAGI and/or MCHP applications, depending on the agency | | | |
| [5] MHBE processes MAGI Medicaid applications. | | | |
| [6] DHR processes non-MAGI application. Although not included in this total, DHR also helps consumers initiate approximately 6,100 MAGI applications per month through MHBX | | | |
| [7] This figure is based on the non-MAGI applications processed by DHMH directly; it does not include any applications process by MHBX or DHR. | | | |
| [8] Includes QHPs and stand-alone dental coverage | | | |
| [9] Includes Food Supplement Program, Temporary Cash Assistance/Welfare Avoidance Grants, Emergency Assistance, Burial Assistance, and Public Assistance to Adults | | | |
| **Source:** Data Collection Tool | | | |

## *Maryland Health Benefit Exchange*

The MHBE IT platform is the primary system determining eligibility for coverage for the vast majority of Maryland residents who enroll in health coverage programs, taking responsibility for all Marketplace coverage applications and for more than nine in ten (93 percent) of Medicaid applications.[9] The agency is responsible for evaluating eligibility for Marketplace coverage and facilitating the selection of QHPs and qualified dental plans (QDPs). It also evaluates people for Medicaid eligibility, specifically eligibility based on MAGI rules that apply to children, pregnant women, parents and other able-bodied adults (see Box 1 for definition of "MAGI"). MHBE offers a range of entry points and types of assistance to consumers, but its website and call center are by far its most important drivers of enrollment. The MHBE also

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[5] 7 CFR 273.2(e)(2)
[6] 7 CFR 273.2(c)(1)
[7] Section 17(b) of the Food and Nutrition Act of 2008, as amended.
[8] 7 CFR 273.2(c)(3)
[9] According to data provided by DHMH for this analysis, approximately 93% of total Medicaid applications received between January and August of 2016 were processed through MHC.

**Box 2: Enroll MHC Mobile App**
MHBE recently introduced the "Enroll MHC" mobile app for the 2017 open enrollment period, which incorporates the full functionality of the desktop version of MHC. It allows consumers to apply for health coverage (Marketplace and MAGI Medicaid coverage), compare prices and QHP ratings, and upload documents for verification using a smartphone camera. The app can provide immediate eligibility determinations for MAGI Medicaid and QHPs, as well as for tax credits and cost-sharing for QHPs. The app also includes a GPS-enabled "find help" feature which uses the applicant's location to identify the nearest sources of in-person assistance, including producers (or insurance "brokers"), local health departments, departments of social services and Connector Entities.

accepts, researches and provides findings for Medicaid and QHP eligibility determination appeals and grievances for all consumers enrolling through the MHC.

### *Maryland Health Connection (MHC)*

Nearly all MHBE and Medicaid consumers use the MHBE's website and eligibility system (the Maryland Health Connection, or "MHC") in one form or another to apply for coverage. They can go to the site on their own, create an online account, and submit an application without any assistance. (As of the current open enrollment period, they also can access MHC via an app on their mobile device. See Box 2.) The MHC is designed to provide an immediate eligibility determination in as many circumstances as possible, and once someone has been found eligible for Marketplace coverage, they are given an opportunity to shop for and select a QHP and QDP. Currently, however, people found eligible for MAGI Medicaid cannot select their Medicaid managed care plan via the MHC website. They, instead, are referred to the state's Medicaid managed care enrollment broker and advised to expect a follow-up packet in the mail with details on their plan options. Consumers who prefer to apply for coverage by phone or in-person typically have applications submitted on their behalf through the MHC even though they do not personally interact with the site's consumer-facing web portal. The MHC also plays an important behind-the-scenes role through its "worker portal," which allows MHBE eligibility workers and Navigators to record case notes in the system that describe application status and any assistance provided to the individual to date. Finally, the MHC provides a complex set of interfaces to Federal and State systems for determining eligibility including the Federal Data Services Hub, the Internal Revenue Service, Immigration and Customs Enforcement and State based wage information.

Currently, the MHC is not designed to evaluate eligibility for non-MAGI Medicaid or for social service programs, which means that some consumers who apply through the MHC are referred to DHR for further review. Specifically, the MHC "flags" when someone appears potentially eligible for non-MAGI coverage, and offers a link to the MyDHR website where the individual can apply for non-MAGI Medicaid and associated benefits. In addition, MHBE sends a report to DHR each month that identifies the individuals who are potentially eligible for Medicaid under non-MAGI rules. The MHC currently does not screen applicants or provide information or referrals for any social service programs.

*Consolidated Service Center*

The MHBE Consolidated Service Center is a full-service support center staffed with customer service representatives who can help consumers file or complete the single streamlined application for health coverage programs, select a QHP or QDP, and triage issues as needed; the service center also handles fulfillment services and is expected to be able to begin assisting Medicaid-eligible individuals in selecting a Medicaid managed care plan starting in 2017.[10] The service center is run for the MHBE by the third-party vendor Maximus, and its employees are trained on both Marketplace and MAGI Medicaid rules. They help consumers file applications through MHC, sometimes using the consumer portal on their behalf or sometimes relying on the worker portal. In general, they are well equipped to handle a high-volume of consumer inquiries of low to medium complexity, but refer highly complex cases to a smaller team of MHBE or DHMH Eligibility Specialists. Cases that are referred to DHMH are sent to the Department's Eligibility Determination Division (EDD) Unit (discussed more below) via a daily log for processing; the file is then returned to MHBE with the disposition status of the case. Consumers may also be referred to local health department or Connector Entities for in-person assistance. In addition, following an eligibility determination, the service center can offer a warm handoff to a producer for assistance in selecting a Marketplace plan.

The number of customer service representatives typically spikes during open enrollment, when the call center employs approximately 400 full-time employees (FTEs). During times of low call volume, this falls to approximately 230 FTEs. The service center can employ remote staff through their telephony technology. Language services are provided through bilingual staff and a language line. Table 2 displays staffing figures in the Consolidated Service Center as well as across MHBE, DHR and DHMH, where such information was available.

| Table 2: Eligibility and Enrollment Staff[11] | |
|---|---|
| | **Total Eligibility and Enrollment Staff** |
| **MHBE** | Consolidated Service Center<br>● Low: 235 FTEs<br>● Open Enrollment: 407 FTEs<br>Connector Entity Program<br>● 125 Navigators statewide<br>MHBE Staff<br>● 68 FTEs |
| **DHR** | Data Not Available |
| **DHMH** | Eligibility Determination Division<br>● 77 permanent FTEs, 19 contractual staff, 10 temporary positions |

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[10] MHBE's fulfillment center processes both inbound and outbound consumer correspondence such as inbound verifications documents, paper applications, outbound system generated notices, ad-hoc consumer notices, 1095-A and 1095-B Forms, and voter registration fulfillment. This center also tracks and records all returned mail in the Client Relationship Management database; this data is then used by MHBE and DHMH to identify necessary manual Medicaid renewals for instances in which a recipient's address has changed but the individual did not report the change.

[11] Source: Data Collection Tool

| Table 2: Eligibility and Enrollment Staff[11] |
| --- |
| Local health department workers<br>● 250 FTEs statewide |

Notably, service center staff have their own database for recording notes on their work with consumers, the Oracle Client Relationship Management (CRM) Database, that is distinct from the MHBE worker portal used by eligibility workers and Navigators (though a shared CRM system between MHBE and DHMH is anticipated in FY 2018). Service center staff are encouraged to record case notes in both the CRM and the worker portal of the MHC – which, as described above, is accessible to others – and use discretion to determine when to update case notes in the MHC worker portal to provide information about the case to other workers not using the Oracle CRM system. However, in part due to the duplicative and time consuming nature of such work, they do not always include case notes in the MHC system. As a result, consumers who seek in-person help from local health departments or Navigators can discover that these workers have no ability to see what already has been done on their behalf or even to identify the current status of their case. Similarly, the service center has its own document management system ("FileNet") for storing documentation scanned into a consumer's online account. As described below, DHMH and DHR use a different document management system. Some, but not all, local health department staff have access to FileNet which in turn can result in duplicative work for caseworkers and consumers when documentation is needed for multiple health and social service programs.

### *Navigators and Consumer Application Counselors*

Beyond the online application portal and Consolidated Service Center, MHBE also offers support through certified Navigators and Certified Application Counselors (CACs) who provide in-person assistance with eligibility and enrollment.

**Navigators** deliver in-person outreach, education, application, and enrollment assistance for both QHPs and MAGI Medicaid coverage. Approximately 140 Navigators are certified by the Maryland Insurance Administration and employed to provide community-based assistance by one of eight regional consumer assistance organizations known in Maryland as "Connector Entities." At their discretion, Navigators can provide in-person assistance in people's homes, but most typically operate out of local health departments, local departments of social services, community-based organizations or other locations, and through enrollment events. They are trained on Marketplace coverage and MAGI Medicaid rules, and have access to both the MHC consumer and worker portals. They do not help people eligible for Medicaid in selecting a managed care plan – a task undertaken by the state's Medicaid managed care enrollment broker – but they can educate consumers eligible for Marketplace coverage regarding how to select a QHP as long as they do not point people to specific plans. Approximately 30% of Navigators are multi-lingual.

Maryland also offers **Certified Application Counselors** (CACs), who receive much of the same training and provide many of the same services as certified Navigators, including education on

available coverage options, application assistance, and facilitation of QHP selection and enrollment. They generally operate out of federally qualified health centers or hospitals and as such, often end up primarily assisting Medicaid-eligible individuals. Unlike Navigators, they have access only to the MHC consumer portal, not the worker portal, and they do not receive funding for their work from the MHBE.[12] There are currently 340 CACs working for 70 different hospitals, health centers and other "sponsoring entities" across the state.

### Producers

Insurance producers (or "brokers") are another important MHBE entry point, particularly for QHP coverage. Licensed insurance producers are required to apply to the MHBE to become designated as an MHBE Authorized Producer and must complete a series of trainings to receive and maintain the designation. Authorized Producers have access to a modified, professional version of the MHC consumer portal through which they can complete the single, streamlined application for their customers and – unlike Navigators and CACs – advise individuals on the selection of a specific health plan.

## Maryland Department of Health and Mental Hygiene (DHMH)

DHMH operates the single state agency charged with implementing and overseeing the Medicaid program. While DHMH delegates the vast majority of Medicaid eligibility determinations to the MHBE or DHR, it retains responsibility for determining eligibility for a select number of special Medicaid programs and initiatives, such as home and community-based waiver programs, the Money Follows the Person demonstration, the Women's Breast and Cervical Cancer initiative and the state's family planning program. The EDD Unit, described in more detail below, conducts the eligibility determinations for these programs. DHMH also provides grants to local health departments for staff to offer in-person assistance to applicants and enrollees, and through the EDD Unit conducts verifications of income and assists with other parts of the Medicaid eligibility determination process.

### Local Departments of Health

DHMH provides grants to Baltimore City and all 23 local health departments in the state to pay for caseworkers who can assist families with children, and others who qualify based on MAGI Medicaid rules, in securing coverage.[13] In 2016, local health departments employed 250 FTEs across the state. These caseworkers primarily focus on providing end-to-end in-person assistance with applications, eligibility determinations and program enrollment for MAGI Medicaid. The caseworkers rely on the single, streamlined application and the MHC for most of their work, and they have access to both the MHC worker and consumer portals. They are trained intensively on MAGI Medicaid rules and are particularly skilled at handling challenging

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[12] "ASCE Program Overview," Maryland Health Benefit Exchange, July 2015. <http://www.marylandhbe.com/wp-content/uploads/2015/07/2-ACSE-Program-Overview.pdf>

[13] <https://mydhrbenefits.dhr.state.md.us/dashboardClient/files/LocalHealthDepartment.pdf>

cases, such as families who require language translation skills or have a complex immigration situation. In many instances, they serve people who have attempted to apply via another entry point, but who have run into trouble and require more extensive assistance. One issue caseworkers face when working with such individuals is that in many instances they cannot see what efforts already have been made by the MHBE's service center to assist them because (as described above) the service center primarily uses its own, separate CRM system that is not accessible to local health departments. As noted above, MHBE and DHMH are teaming together to develop a common CRM database for implementation in 2018 that can be used by all workers.

Despite the "soup-to-nuts" service goal of local health departments, caseworkers face some hurdles to providing a comprehensive enrollment experience. They cannot assist Medicaid-eligible individuals with the selection of a Medicaid managed care plan, which is a responsibility carried out by Maryland's Medicaid managed care enrollment broker. More significantly, though they rely on the single, streamlined application and the MHC, if issues arise with a Marketplace determination, they cannot offer assistance. As a result, when someone appears eligible for Marketplace coverage and wants help completing the process and selecting a QHP or QDP, he or she must be referred to a Marketplace resource – a Connector Entity, Authorized Producer or the Consolidated Service Center. Usually, people must return to the MHC website or travel to a different location for in-person assistance as only in two instances are Navigators co-located in the same building as the local health department. Even when co-location occurs, local health department caseworkers are not required to facilitate "warm handoffs." In practice, this means that people who have sought help from a local health department may have to go to the "back of the line" if it turns out they qualify for Marketplace coverage and want help from a Navigator in selecting a QHP or QDP.

Similarly, local health department caseworkers are not specifically trained to assess individuals for potential eligibility for other social service programs and cannot assist with non-MAGI Medicaid determinations. They must refer individuals who appear potentially eligible for social service programs or non-MAGI Medicaid to a local department of social services. Again, while a small number of local health departments and local social service departments are co-located, even in these instances there are often only informal protocols for coordination in place (e.g., individuals must self-select which office best meets their needs, or staff at an information desk might triage them to one or the other based on the services they are seeking). And, when an agency caseworker determines that referral to a social service program is warranted, there are currently minimal processes or IT systems in place that can facilitate a warm handoff or the sharing of information across agencies.

### Eligibility Determination Division (EDD)

DHMH also operates an Eligibility Determination Division (EDD) Unit that primarily provides back-end eligibility and enrollment services for both MAGI and non-MAGI Medicaid groups. In addition to processing paper applications received via mail or through other state entities (e.g., correctional facilities), the approximately 77 full-time employees that staff the EDD are charged

with handling the complex Medicaid cases transferred from the MHBE Consolidated Service Center or a Connector Entity/Navigator; conducting verifications in support of Medicaid eligibility determinations; contacting individuals whose eligibility is on hold pending submission of necessary documentation; and developing program reports, among other services. The EDD also provides end-to-end eligibility and enrollment support for a select number of non-MAGI programs (including a wide range of home and community based waiver services). This includes processing non-MAGI applications triaged to the EDD through a DHR entry point and staffing a call center (separate from the MHBE service center) that accepts calls on non-MAGI eligibility and enrollment.

### *Hospital Presumptive Eligibility Program*

Established by the ACA, the DHMH Hospital Presumptive Eligibility (HPE) program allows hospitals to enroll eligible individuals into Medicaid on a temporary basis when they show up in a hospital. Hospitals make their eligibility determinations based on self-attested income and demographic information collected from patients. Participants in the HPE program receive time-limited Medicaid benefits while their application for full Medicaid coverage is submitted via MHC for a full eligibility determination. Hospitals participating in the program have DHR co-pay workers who have access to a full range of eligibility and enrollment systems, including the MHC worker portal and CARES (discussed below) to support their work with consumers.

## *Maryland Department of Human Resources (DHR)*

DHR determines eligibility for a broad array of social service programs, including for over 630,000 FSP recipients, 150,000 TCA customers, 42,000 Temporary Disability Assistance Program recipients, 73,000 Emergency Cash Assistance to Families with Children, 140,000 Energy Assistance cases and more. It also determines eligibility for a number of non-MAGI Medicaid eligibility groups, including seniors and people with disabilities who qualify for Medicaid based on their income. The agency is in the midst of planning a major new data sharing platform, known as MD THINK, to support its work and provide better integrated services to customers across a broad array of health and social service programs (see Box 3).[14]

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[14] "MD THINK - Cost Allocation and Methodology Plan." Maryland Department of Human Resources. August 2016.

*MyDHR*

Individuals seeking health coverage or social services may visit DHR's online screening and application tool, myDHR, or download the mobile app to apply for and receive information on the programs for which they can qualify. Once an individual has created a myDHR account, he or she can complete an application and upload verification documentation (including via smartphone) to determine potential eligibility across a broad range of available state programs, including Medicaid, FSP, TCA and more.[15] Information collected through the application flows into CARES, the DHR eligibility system, and is assigned to a local department of social services for caseworker processing based on the county in which the applicant resides. DHR caseworkers at local departments of social services review and verify submitted information and determine eligibility for DHR-administered programs (i.e., non-MAGI Medicaid and other social service programs) in CARES. If an individual appears potentially eligible for Marketplace coverage they are directed to the MHC website or the MHBE Consolidated Service Center to submit an application through the MHC.

> **Box 3: Maryland Total Human services Information NetworK (MD THINK)**
> The recently proposed Maryland Total Human services Information NetworK (MD THINK) will serve as a secure cloud-based, shared data repository capable of supporting multiple health and human services programs across the state. It will be composed of a system of modular, interconnected components, including a common data repository, shared service elements and resources and mission specific applications. Led by DHR, MD THINK is being designed to provide eligibility determinations, case management, document management, enrollment, cross program referrals and analytics for a range of health and human services programs. As proposed, MD THINK would fulfill some of the recommendations described in this report, contributing to significant maintenance and operation cost savings, reduced error rates, improved efficiency of eligibility and enrollment processes, more accurate measurement of programmatic data, and a more consumer-centric approach to serving applicants and beneficiaries of health and social service programs. Federal funding for the project is

***Local Departments of Social Services***

DHR also makes in-person assistance available to applicants and enrollees in each Maryland county through local departments of social services. Caseworkers are able to help individuals complete applications for DHR-administered health and social service programs. Each local department of social services also operates a self-service computer lab for individuals seeking to apply for MAGI Medicaid or Marketplace coverage using the MHC website and non-MAGI Medicaid and other social services programs via myDHR. Caseworkers are trained on a broad range of program rules, including for MAGI and non-MAGI Medicaid, have access to the MHC

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[15] Additional programs include the Temporary Disability Assistance Program (TDAP), Medical Assistance Long Term Care, the Maryland Energy Assistance Program and the Electric Universal Service Program. Individuals can also complete a Child Support Enforcement (CSE) application to apply for child support enforcement services.

worker portal, and are available to answer questions that come up for people using the computer lab related to the Medicaid program. However, due to resource constraints and in keeping with the self-serve structure of the MHC they typically do not provide one-on-one help to self-service computer lab customers, and are unable to provide assistance or answer any questions about Marketplace coverage. Instead, individuals who require additional assistance with MAGI Medicaid or Marketplace programs are referred to local health departments, Connector Entities/Navigators, or the MHBE call center. As described above, while local departments of social services are occasionally co-located with local departments of health or have a Navigator on site on a part-time basis, people often have to travel to a different location for this type of in-person assistance.

### Community-Based Organizations (CBO) and Other Partners

DHR partners with a number of CBOs that enroll hard-to-reach individuals and populations. Dispersed throughout communities, these organizations assist individuals in completing applications for health coverage and social service programs and submit them on behalf of their clients to DHR for processing. DHR also has contracted with the Benefits Data Trust to establish the Maryland Benefits Center which provides comprehensive outreach and application assistance based on a crosswalk of client registries for various programs (e.g., Medicaid, TANF SNAP, and Energy Assistance) to identify those who are enrolled in some, but not all, of the programs for which they might be eligible. For example, CBOs assisted with over 34,000 SNAP applications, in addition to numerous TANF, Medicaid and Energy Assistance applications, using myDHR in fiscal year 2016.

CBOs and other partners additionally serve a critical function administering eligibility and enrollment in niche social services such as refugee cash assistance, energy assistance, homeless services, emergency feeding grants, and employment and training programs.

## Secondary Entry Points to Health Coverage Programs

Maryland also has other types of entry points that facilitate people's access to health coverage and social service programs. While the entities below do not issue eligibility determinations for Medicaid, Marketplace or social service programs, they serve as key referral points and as a source of assistance that can facilitate enrollment.

### Maryland Department of Juvenile Services (DJS)

DJS Case Management Specialists (CMS) complete Medicaid applications on behalf of children in DJS private residential programs. Using a paper application, the DJS CMS provides the requisite application information on behalf of the child as would a parent, guardian or custodian, including documentation (court order) showing that the child is in the care and custody of DJS, and submits it to the local department of social services for processing. Staff at the local department of social services process the application and make an eligibility determination. Once a determination is made, a notice is generated informing the CMS of the

child's eligibility, and requiring the CMS to select a Managed Care Organization (MCO) on behalf of the child. Caseworkers are instructed to choose the MCO used by the residential provider that is currently serving the child.

### *Maryland Department of Aging (MDOA)*

MDOA operates 20 local Maryland Access Point (MAP) offices throughout seven regions of the state that provide a single point of entry for individuals seeking long-term support services. Each MAP is a partnership between local Area Agencies on Aging (AAA) and a Center for Independent Living (CIL) organization associated with the region, the latter of which primarily provide assistance for people with disabilities. The large majority of MAPs around the state are housed within an AAA, but one is housed within a local health department. Approximately 130 certified "Options Counselors" staff the sites, working with individuals to address their long-term care needs. If during the course of this assessment an individual appears to need health coverage or social service programs, the Options Counselor can assist the person in submitting an application.

## V. Best Practices from Other States

In recognition of the potential for greater coordination of health and social service programs, a number of states have begun to consider the ways in which data, policies, processes, staff and/or technologies can be used across programs to streamline eligibility and enrollment. In this report, we present findings on best practices for improving coordination and efficient enrollment from our interviews with Colorado, Idaho, Michigan and New York, as well as from the published literature on the topic. As described in more detail in Appendix A, these four states were selected based on a combination of factors, including whether they were identified in the published literature as demonstrating promising practices, the extent to which they share common characteristics with Maryland, and whether they were recommended by one or more of the three major agencies in Maryland charged with administering health and social service programs.

It is important to note that none of the states exactly match Maryland's circumstances and, indeed, some have taken a dramatically different approach to operating their health and social service programs. As a result, it will not always be possible for Maryland policymakers to readily "borrow" the best practices from other states without sweeping changes to the state's fundamental approach to operating health and social services programs. Further, it should be recognized that new IT systems evolve rapidly over time, so the discussion of best practices focuses on the eligibility processes and policies in other states and not necessarily the states' specific IT platforms. Some states, like Colorado, are currently taking further steps to improve their systems. In the recommendation section that follows, this analysis takes into account Maryland's current approach and generally offers options consistent with the state's existing organizational structure.

Specifically, two states interviewed for the report – Colorado and New York – administer health and social service programs across multiple state agencies as in Maryland, while Michigan and Idaho have unified administration of all such programs under one agency. In Colorado, the Department of Health Care Policy and Financing administers Medicaid, while the State-based Marketplace, Connect for Health Colorado, administers Marketplace programs and the Department of Human Services and other agencies administer most social service programs. In New York, Medicaid and Marketplace programs are under the state Department of Health, while social service programs are administered by a variety of agencies including the Office of Children and Family Services, Office of Mental Health, Office of Alcoholism and Substance Abuse Services and others. In contrast, in Michigan and Idaho, all health and social service programs are administered by the Department of Health and Human Services and the Department of Health and Welfare, respectively.

Each state examined in this review relies to some extent on local health departments or departments of social services to facilitate eligibility determinations and enrollment in health and social service programs, with some offering a greater degree of discretion to local offices. For example, Colorado follows a "state supervised, county administered" model, where local offices maintain discretion around several aspects of the eligibility and enrollment process, including variations in eligibility levels for some programs. On the other hand, Idaho uses a more centralized model where eligibility and enrollment procedures are largely standardized across the state, though local workers are given extensive training on how to actively work with clients to identify the programs and services that are most likely to address barriers to self-sufficiency.

The best practices identified in this section include everything from sweeping changes in a state's organizational structure and culture to more targeted efforts to align health and social service program policies, improve business processes, strengthen integration of IT systems and the sharing of data, and use data to monitor and improve coordination and effective enrollment on an ongoing basis. As discussed in the recommendations section, several of the practices described below already are being contemplated by Maryland agencies and, in fact, a number are incorporated into existing plans such as for MD THINK.

### *Fundamental Organizational and Cultural Change*

### 1. Establish coordinated oversight of health and social service programs and an integrated eligibility and enrollment system.

Both Idaho and Michigan house their health and social service programs "under the same roof," reflecting a belief that a single agency makes a profound difference in the state's ability to provide efficient, consumer-oriented services. Both states have a single eligibility system for and eligibility workers trained on all health and social service programs, a unified renewal process, and the ability to ensure that when consumers update information for one program, it is automatically updated for all other health and social service programs. As one interviewee explained, a consolidated approach means that the state is not in the position of trying to

connect disconnected programs. Notably, however, unlike Maryland, both Idaho and Michigan rely on Healthcare.gov to conduct Marketplace determinations and so must include "handoffs" to the federally-facilitated Marketplace when they find consumers who require Marketplace coverage. In contrast, states without a single unified system noted it is inherently challenging to coordinate a consumer experience across agencies, but, that they had their hands full simply aligning eligibility rules and systems among health coverage programs.

Even where health and social service programs are not administered by the same agency, states can still take steps to foster greater integration across programs. For example, Colorado's Medicaid, Marketplace and social service programs are administered by separate state agencies. However, a culture shift spearheaded by Governor John Hickenlooper – who made enhanced collaboration across agencies a top priority of his administration – has succeeded in greatly streamlining eligibility and enrollment process across programs. Steps taken in support of this effort include establishing a shared governance structure for the state's eligibility systems, creating inter-agency workgroups that meet regularly and developing a work plan to share common resources across agencies. These initiatives are guided by an executive steering committee that meets monthly, and which includes senior leadership from the governor's office and from each relevant agency. Through enhanced collaboration, Colorado has made significant improvements to the organization of entry points for health and social services in the state, including aligning redeterminations across programs, matching eligibility periods, streamlining eligibility rules, and developing a streamlined cross-program application.

**2**. **Pursue a paradigm shift away from program-by-program eligibility determinations to a consumer-centric approach.**

Even short of sweeping organizational change, however, interviewees and our literature review highlighted the importance of establishing and reinforcing a fundamental paradigm shift away from a program-by-program eligibility and enrollment approach to a consumer-focused approach. In states such as Idaho, this consumer-focused approach means that eligibility workers are trained to begin client interviews with questions about a family's circumstances and needs. Only after they assess the full spectrum of family needs do they then work with the family to secure appropriate services. This shifts the onus of determining what programs and services a family might need from consumers – who are not well-positioned to understand the potential suite of services available to them – to caseworkers with the requisite training to understand a family's needs and match them to available services. Eligibility workers are not expected to know all of the intricate details of the eligibility rules of Medicaid and social service programs, but rather to ask the right questions to solicit needed information. The information they gather is entered into an integrated eligibility system so that the business rules engine – not the worker – is responsible for applying nuanced eligibility rules.

**3. In integrated systems, preserve consumers' right to choose selected health and social service programs.**

In states that have adopted  highly integrated approaches to eligibility for Medicaid and social service programs, it remains important to give consumers the chance to pick and choose among programs. Indeed, the ACA requires states to provide consumers with a "health coverage-only" option when they are submitting an application. Both Idaho and Michigan have found effective strategies for doing so. In Michigan, for example, consumers begin the application process by deciding between completing a "health coverage-only" application or one that allows them to apply for multiple benefits. In instances where people choose the former option, once they have provided the information needed to determine eligibility for health insurance programs, they are again given the opportunity to apply for SNAP, TANF and other social services programs. The state estimates that some 90 percent of its enrollees are enrolled in multiple health and social service programs. Similarly, Idaho offers a health coverage-only option through its online enrollment portal. Eligibility workers in the state also follow an "informed choice" model, where workers advise customers of the programs for which they may be eligible but ensure they are interested before helping them to sign up.

### *Alignment of Policies Across Programs*

Within constraints established by federal law, states have some discretion to align eligibility and enrollment policies across health coverage and social service programs, making it easier to create effective and efficient enrollment procedures.

**1. Align definitions and requirements across programs.**

Several states have taken steps to align eligibility definitions and requirements across health coverage and social service programs in the interest of simplifying the application and enrollment process and increasing access to services for families. For example, program administrators in Idaho gained legislative approval to slightly increase the eligibility threshold for child care set by the state in order to align it with the federal eligibility limit for SNAP, simplifying the application process and reducing confusion.[16]

**2. Establish automatic linkages in eligibility between health and social service programs.**

The federal government has provided states with some flexibility to establish an automatic eligibility link between SNAP and/or TANF and Medicaid coverage. The option, which is explained in detail in a letter sent to states on August 31, 2015,[17] takes advantage of the reality that people who are eligible for SNAP or TANF, by definition, are low-income and meet strict

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[16] Isaacs, Julia B., Michael Katz, David Kassabian. "Changing Policies to Streamline Access to Medicaid, SNAP and Child Care Assistance Findings from the Work Support Strategies Evaluation." Urban Institute. March 2016. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000668-Changing-Policies-to-Streamline-Access-to-Medicaid-SNAP-and-Child-Care-Assistance-Findings-from-the-Work-Support-Strategies-Evaluation.pdf
[17] https://www.medicaid.gov/federal-policy-guidance/downloads/sho-15-001.pdf

citizenship and/or legal immigration requirements in order to qualify for these programs. New York has used the option to deem its TANF recipients automatically eligible for Medicaid despite minor differences in the household composition and income counting rules for the two programs. By doing so, it has eliminated the need for TANF recipients to submit a separate application for health coverage.

**3. Align timing of renewals or automatic renewals across programs.**

States also have implemented improvements to the recertification process, reducing the administrative burden on enrollees of maintaining coverage and on program staff of processing renewals. This includes aligning renewal dates across programs and modifying redetermination policies to allow for automatic administrative renewal. For example, Colorado, Idaho and Michigan have all implemented policies that aligned recertification dates statewide. Colorado has aligned redetermination dates across Medicaid, SNAP, TANF and Adult Financial programs and created redetermination forms that prepopulate with client information pulled from the eligibility system or other pertinent data systems. Idaho implemented similar changes, but also established a process for automatic renewal of Medicaid eligibility whereby SNAP eligibility data and data from secondary sources is used to automatically renew Medicaid eligibility for beneficiaries without them having to take any action. This approach has dramatically reduced the number of cases closed due to procedural issues and Medicaid churn in Idaho.[18] Maryland allows online renewal of MAGI Medicaid and Marketplace coverage but has not aligned recertification dates or linked Medicaid redetermination with eligibility for SNAP or other programs.

*Improve Business Processes*

**1. Empower eligibility workers to provide same-day, "end-to-end" service.**

Some states have grounded their eligibility and enrollment approach in the principle that client issues, including the need for an eligibility determination, should be resolved during a single contact with a client. In practice, this means ensuring that applicants or enrollees can work with a "decision-maker" or someone authorized to facilitate the eligibility and enrollment process from end-to-end; that information submitted as part of the application process is verified, through electronic verification systems or otherwise, in as close to real-time as possible; and that the decision-maker is equipped to issue an eligibility determination immediately following verification. Idaho has aggressively pursued this model by establishing a "universal workforce" approach that puts a decision-maker at every point of client contact. Under this model, "self-reliance specialists" in field offices manage every aspect of eligibility determinations for a range of health coverage and social service programs and are empowered to make decisions "on the spot" during in-person interactions. If wait times are running long at a field office, individuals may be placed in a conference room to connect with a self-reliance specialist stationed at state

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[18] Issacs, et. al, 2016.

processing centers where staff are able to take applications and complete eligibility determinations by phone.

One key to designing business processes that facilitate same-day service is the development of technology that can support them. For example, in implementing its universal workforce approach, Idaho has leveraged its single eligibility system, a new integrated case management system that allows for the sharing of work across the state, automated verification technology that allows the state to tap federal and state data sources for automatic verifications, and data warehouses for program monitoring. Other states with State-Based Marketplaces, including New York, Rhode Island and Washington, have elected to allow consumers to choose their Medicaid MCOs through the Marketplace website, making it possible for Medicaid beneficiaries to complete the process of enrolling in coverage and securing a plan in a single sitting.[19]

**2. Establish protocols that facilitate coordinated handoffs across programs.**

In instances where referrals across programs are necessary, it is important to put in place business protocols that facilitate "warm" handoffs. This may start with convening a variety of stakeholders to develop related training protocols. For example, Colorado operates a "staff development center," which develops training materials for county workers through the collaborative input of personnel from multiple state agencies. States also can implement protocols that facilitate direct communication among eligibility workers around a given case. Illinois, which has moved to integrate child care assistance processes for individuals receiving SNAP and CHIP, has taken steps in this area. It has developed a liaison list that provides key contact information for each major program, enabling eligibility workers to directly and efficiently communicate with one another and resolve client issues together, rather than relying on the customer to be the intermediary between programs.[20] Other states have moved to integrate their intake processes for individuals seeking access to multiple programs, particularly for individuals seeking in-person assistance with the application process. In South Carolina, where separate agencies administer Medicaid and SNAP, the state has established a "unified lobby" environment where intake staff at county offices assess each client's potential needs and triage him or her to the appropriate office or caseworker window for service.[21]

*Integrated IT Systems*

Changes to program eligibility and enrollment policies and business processes often must be coupled with changes to the information technology systems that improve cross-program

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[19] Manatt Health Solutions, "Report from the States: Early Observations About Five State Marketplaces," December 2013, http://statenetwork.org/wp-content/uploads/2014/11/State-Network-Manatt-Report-from-the-States-Early-Observations-about-Five-State-Marketplaces.pdf. (Accessed October 22, 2016).
[20] Hahn, Heather, Ria Amin, David Kassabian, Maeve Gearing. "Improving Business Processes for Delivering Work Supports for Low Income Families: Findings from the Work Support Strategies." Urban Institute. March 2016. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000670-Improving-Business-Processes-for-Delivering-Work-Supports-for-Low-Income-Families-Findings-from-the-Work-Support-Strategies-Evaluation.pdf
[21] Ibid.

integration, enhance consumers' access to services, and ultimately support new and better ways of doing business. However, a number of interviewees for this analysis highlighted that it is important to recognize that IT systems alone cannot resolve inefficient business processes or misaligned program policies and should support, rather than drive, planned reforms. Also of note, systems integration faces legal and regulatory barriers which may prevent the free sharing of data across programs, such as the Family Educational Rights and Privacy Act (FERPA) and other confidentiality requirements. States must consider these limitations when developing mechanisms for sharing data.

**1. Implement an integrated eligibility system.**

A number of states have implemented or are moving to implement integrated eligibility systems that are programmed to include the rules of multiple health coverage and human service programs, able to access and evaluate data from multiple sources to verify application information and issue eligibility determinations across programs, and which also often contain functionality to manage workflow or record case notes.[22] States who have built integrated eligibility systems – including Idaho and Michigan – typically have done so incrementally, starting with a set of core programs and incorporating rules for other programs into the system on a rolling basis. For example, New York currently operates an integrated eligibility system for MAGI Medicaid and Marketplace determinations through its State-based Marketplace, and is now working to create a plan to add non-MAGI Medicaid rules to the eligibility system.

**2. Implement a shared data platform to reduce duplication and streamline eligibility and enrollment processes across programs.**

The use of shared data repositories that allow for the seamless and automatic exchange of relevant data across state health and social service programs is another key tool for expanding access to programs and reducing administrative inefficiencies. For example, Illinois is working to integrate all of its existing data matching interfaces into a new integrated system to preclude the need for workers to access and review multiple systems and sources of information when verifying eligibility; instead, the eligibility system provides a unified view of all available verification data across all relevant programs so that the worker is able to confirm that necessary eligibility factors have been met for a given program.[23] Illinois's platform also allows for updates to client information in one system or program to be shared and incorporated into the client record across all systems and programs, reducing duplicative data entry for state workers and mitigating administrative burden on consumers.

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[22] Loprest, Pamela J., Maeve E. Gearing, David Kassabian. "States Use of Technology to Improve Delivery of Benefits: Findings from the Work Support Strategies Evaluation." March 2016. http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000671-States%27-Use-of-Technology-to-Improve-Delivery-of-Benefits-Findings-from-the-Work-Support-Strategies-Evaluation.pdf

[23] Shaw, Terry, and Lucy Streett. "State Innovations in Horizontal Integration: Leveraging Technology for Health and Human Services." March 24, 2015. Center on Budget and Policy Priorities and Social Interest Solutions. http://www.cbpp.org/sites/default/files/atoms/files/3-23-15fa.pdf

**3. Consider more discrete IT tools to create efficiencies across programs.**

Beyond fully integrated eligibility systems or shared data platforms, more discrete IT tools exist that can assist states in connecting individuals to services in a more streamlined fashion. For example, **integrated CRM systems** allow all caseworkers to record and view case notes and manage workflow in a common IT system, thereby eliminating the need to search multiple systems for information regarding the status of an individual's case. Similarly, **integrated document management systems** can offer a common repository where scanned documents can be stored and accessed, dispensing with the need for eligibility workers to make duplicative requests to consumers regarding proof of their eligibility. Pennsylvania, for example, has moved to implement a new centralized document management system that will be accessible to state and county eligibility workers and will incrementally incorporate documentation collected across several state programs, including its child support, Medicaid and CHIP programs, and eventually its SNAP and TANF programs.[24] Finally, **eligibility screening tools** can be leveraged to use information submitted during the application process for a given program to assess potential eligibility in other programs. Similar to the myDHR portal, these tools collect information from the consumer to assess potential eligibility for a wide range of programs and provide links or other guidance on how an individual may receive additional information and apply for other programs.

*Data Analytics to Drive Performance Improvement*

**1. Collect and analyze program data for continuous improvement.**

States increasingly are looking to ensure that their efforts to improve eligibility and enrollment are data-driven and rooted in the actual experience of consumers. California, for example, recently adopted state legislation that requires public reporting of data on key metrics related to eligibility and enrollment across Medicaid and Marketplace coverage. Data published to date offer notable insights regarding pathways to public health insurance coverage in the state. For example, resultant reports have demonstrated the extent to which the initial pool of applicants match early estimates of the eligible uninsured population, show the newly cyclical nature of health insurance applications that match the Marketplace open enrollment period, and reflect the extent to which individuals remain in health coverage over time. California will be able to use this information to improve the efficiency of enrollment processes through a variety of mechanisms. It could, for example, investigate reasons for variation in application completeness across application sources or leverage data to identify best practices across counties.[25]

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[24] Ibid.

[25] Colby, Maggie and Sarah Croake. "Reporting on Pathways to Health Insurance Coverage: California's Experience." Mathematica Policy Research. February 2016. https://www.mathematica-mpr.com/our-publications-and-findings/publications/reporting-on-pathways-to-health-insurance-coverage-californias-experience

## VI. Recommendations

Maryland has made significant progress in establishing a single, unified approach to eligibility determinations for health coverage programs, including Marketplace coverage and MAGI Medicaid. Unlike that vast majority of states that rely on Healthcare.gov, it can provide most families with a determination of their eligibility for Marketplace and most Medicaid coverage in a single session. The DHR handles a high volume of cases for social service programs and is in the midst of an ambitious planning process to create MD THINK, a key tool for increasing efficiency and promoting coordination across health and social service programs. At the same time, the current reality is that Maryland families still often must work with multiple entry points if they happen to have members who qualify for coverage on different grounds (e.g., MAGI and non-MAGI Medicaid) or certainly if they require both health care and social services. This imposes an administrative burden on Maryland residents, and, as importantly, may result in the state expending unnecessary resources to gather and verify information on multiple occasions from the same applicant.

The following recommendations are designed to offer specific, actionable ideas for how Maryland can maximize access to publicly-funded health and social services in Maryland; 2) reduce duplication, inefficiency, and costs; and 3) maximize federal fund participation. They also are designed to be consistent with the Hogan-Rutherford administration's strong commitment to improving customer service in Maryland, particularly its emphasis on ensuring that information and services are convenient and accessible; that consumers are treated fairly and consistently; and that the state will be proactive and anticipate the needs of consumers.[26] In reviewing the recommendations, Maryland policymakers will want to consider the full range of issues that can affect the feasibility and cost-effectiveness of implementation, including the availability of federal funding, but also the need to meet federal and state requirements,, including aligning with various IT privacy and security standards and ensuring the security of all constituents. It will be particularly important to monitor any actions taken by the new Trump Administration and Congress that could affect Medicaid or Marketplace funding for the changes proposed below.[27]

### 1. Establish a working group on coordination of health and social service programs.

At the base of any effort to improve access to health and social services for consumers is a strong working relationship among the major agencies responsible for such services. Maryland

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[26] For more details on the Administration's customer service pledge, see: http://www.maryland.gov/pages/customerservice.aspx.

[27] Currently, the federal government matches 90 percent of the cost of approved investments in the development of Medicaid eligibility systems and 75 percent for maintenance. The 90/10 matching rate is rooted in statutory language that pre-dates the ACA, but was limited to funding for MMIS systems until the Obama Administration issued regulations in the aftermath of the ACA that allowed it to be used for eligibility and enrollment systems. To date, legislative proposals aimed at repealing the ACA have not targeted the 90/10 funding, but they could potentially do so in the future. Moreover, the Trump Administration could issue a new regulation to eliminate the availability of 90/10 funding for eligibility and enrollment without legislative action.

has developed a number of mechanisms for promoting coordination among DHMH, MHBE, and DHR, but the state could consider enhancing these efforts by establishing a working group specifically dedicated to finding more efficient and consumer-friendly ways to improve access to health and social service programs. The Taskforce could either build on the existing SAC, or, as in Colorado, could be led out of the Governor's office to ensure broad participation and strengthen cross-agency collaboration. It could be charged with gathering the data needed to identify opportunities for improvement, convening the key stakeholders, reviewing the recommendations in this report and from other sources, and ensuring that agency-specific plans on IT systems and business processes that affect consumers' access to health and social services are strongly coordinated and driving toward the goal of efficient, consumer-focused service.

**2. Establish and report on key performance metrics on access to health and social service programs.**

In conducting this analysis, it was clear that each agency can provide data to varying degrees on its role in helping consumers secure access to health and social service programs. For example, MHBE routinely issues data on its progress enrolling people in coverage, while DHMH and DHR each regularly submit data to their federal partners on application and enrollment outcomes and DHR works with the Benefits Data Trust to conduct outreach to Medicaid beneficiaries not enrolled in SNAP. Nevertheless, it is challenging to secure data on consumers' experiences across health coverage programs and, to an even greater degree, their experiences across health and social services programs. To address this gap, Maryland should consider creating a set of performance metrics that assess access to health and social services and the effectiveness of coordination efforts, and require regular public reporting on the metrics. They should include data on applications and renewals, processing times, and eligibility decisions, but also the following kinds of "cross-agency" data that is particularly difficult to obtain:

- **Coordination between Medicaid and SNAP**. Maryland could increase efforts to track the extent to which people enrolled in Medicaid are also enrolled in SNAP and vice-versa, focusing on individuals below 138 percent of the federal poverty line (the income cut-off for Medicaid coverage for adults). Such a metric would provide valuable information on the extent to which consumers who require both health and social services are able to access those services.

- **Consumer assistance across entry points.** To the extent feasible, Maryland could gather data on key patterns in consumers' use of entry points, such as the share of people who begin an application online, but then seek assistance from the call center or at a local health department. If it is not feasible to gather such data for all beneficiaries, agencies could be asked to perform the analysis on a representative sample. It will be far easier to systematically assess issues and identify areas for improvement if Maryland can gather more data on how consumers actually use the various health and social service entry points in the state.

- **Outcomes for people identified as potentially eligible for Medicaid under non-MAGI rules.** When the MHBE identifies individuals who are potentially eligible for Medicaid under non-MAGI rules, it refers them to DHR for further evaluation. Currently, however, there is no easy way to track what happens to these individuals, making it difficult to assess the effectiveness of this handoff.

**3. Establish a seamless approach to evaluating an individual for all forms of Medicaid eligibility (i.e., both MAGI and non-MAGI Medicaid).**

The states furthest along in coordinating health and social service programs have established integrated eligibility systems (although, as noted above, they do not share Maryland's use of a State-based Marketplace). Now that Maryland has established a reliable platform for conducting Marketplace and MAGI Medicaid determinations, it is important to work toward a seamless eligibility and enrollment experience for Marylanders seeking both MAGI and non-MAGI Medicaid. Maryland may be able to do so by better coordinating the systems that support MAGI and non-MAGI Medicaid eligibility determinations to more seamlessly transfer application information and eligibility results, effectively making the "handoffs" between systems and consumer assistance workers less necessary or even invisible to consumers. Over time, the state also could consider even more sweeping change that includes the further integration of health and social service eligibility systems, though this does not appear to be a realistic option in the short-term.

**4. Create a data platform to facilitate data exchange between health and social service programs.**

As Maryland assesses whether to further integrate its eligibility systems, DHR has proposed a data exchange platform, MD THINK, that would allow the major agencies in the state to securely share data across a common platform even as they retain their own eligibility systems. It, for example, would ensure that when a family updates its address with DHR for SNAP purposes this information is updated for Medicaid purposes. (See Box 3 for a more detailed description of MD THINK.) Such a system holds the promise of contributing to a significantly more efficient and consumer-friendly experience across health and social service programs and a platform from which to implement a range of discrete recommendations aimed at stronger coordination. As discussed above, it will be important for Maryland policymakers to carefully monitor the availability of the federal Medicaid matching funds that are expected to finance much of this new system given the new Trump Administration and Congress's strong interest in repealing key elements of the ACA.

**5. Create automatic eligibility linkage between TANF/SNAP and Medicaid.**

Using the option available under federal law, Maryland should consider automatically providing Medicaid coverage to TANF and SNAP beneficiaries with income below a specified level. DHMH and DHR are currently considering this option as part of the proposed MD THINK platform. This approach, adopted in New York, avoids the need for DHR staff to refer people to Medicaid via

the MHBE or a local health department for further action if they also need health coverage. In effect, it greatly simplifies the process of enrolling in Medicaid for an important subset of low-income consumers who already have established their income, immigration status, and other components of eligibility. By doing so, Maryland can avoid unnecessary administrative costs and hassle for consumers already enrolled in TANF or SNAP. To pursue this option, Maryland will need to work with the Center for Medicaid and CHIP services to secure approval of a state plan amendment.

**6. Review the roles of eligibility workers and other assisters to provide a seamless experience to consumers.**

Maryland should review the roles and responsibilities of eligibility workers, consumer assisters and Navigators to assess how they could be revised to provide consumers with a seamless experience when they seek coverage. Currently, the experience of consumers can vary significantly based on where they apply. For example, a local health department can fully evaluate eligibility for MAGI Medicaid, but cannot assist people with non-MAGI coverage or in selecting a Marketplace plan. Similarly, consumers who apply via a local department of social services can get help with social service programs, but may not be able to get an answer on their eligibility for Medicaid if they run into issues (e.g., require extra assistance with verification) and will be referred elsewhere for assistance with Marketplace plan selection. Navigators can help with Marketplace coverage and MAGI Medicaid, but cannot assist people in selecting their Medicaid managed care plan. In reviewing the roles of various assisters, Maryland should specifically assess whether local health department workers and local department of social services workers could be trained to assist people with Marketplace coverage, as well as whether Navigators could help with Medicaid managed care enrollment. As discussed in more detail below, if a seamless experience cannot be achieved in the short-term, it becomes even more important to have effective coordination across assisters (Recommendation 8).

**7. Provide Medicaid beneficiaries with the ability to select a Medicaid managed care plan through MHC.**

On a related note to Recommendation 6, it is important to have an IT infrastructure that supports consumers in securing coverage, not just eligibility for insurance. Currently, however, consumers who are found eligible for Medicaid through MHC cannot immediately enroll in a managed care plan, preventing them from completing the eligibility and enrollment process in a single setting. As New York, Rhode Island and Washington State have done, the MHBE already is looking to add this functionality to its website, allowing people to have a complete end-to-end experience and to more quickly begin receiving managed care.

**8. Systematically build referrals and "warm handoffs" between DHR, DHMH, and MHBE.**

As Maryland continues to build stronger connections between health and social services, it will still need to rely on "handoffs" between agencies. To ensure that they are as smooth as possible, we recommend that Maryland consider the following:

- **Systematic procedures for identifying when people would benefit from referral**. While it sounds like many of Maryland's caseworkers informally ask families about whether they need services from other agencies, Maryland may want to consider creating a more systematic approach to identifying when clients would benefit from referrals. For example, the state could establish workflow protocols and offer training that ensure local health department workers routinely check whether families would like help with other social service programs. Similarly, the MHBE should consider adding an alert at the end of the application process advising low-income clients that it appears they may well be eligible for SNAP or other social service programs and providing information on how to apply if they are not already enrolled.

- **Connecting clients to a specific individual.** The key ingredient to effective handoffs is identifying a specific person with whom a client can turn for information and help. It is well established that the success rate of handoffs when people are given a general phone number to call or name of a website is extremely low. Local health departments and local departments of social services have helped to address in some jurisdictions by co-locating together. However, even though it is easier to walk across a hallway than to visit an entirely different site, such an approach still requires clients to start anew with a different eligibility worker.

- **Tracking outcomes**. To identify opportunities to improve procedures, Maryland should consider systematically tracking the effectiveness of handoffs. How often are clients who are sent to another agency for helping following up? How often are they securing the services? It increasingly is becoming common practice to require closed-loop referrals in clinical settings, and the same principle that it is important to receive feedback on the outcome of a handoff also applies with respect to enrolling people in coverage and social service programs.

**9. Establish integrated "back end" systems for verification and client relationship management across health coverage programs.**

To increase the efficiency of eligibility and enrollment efforts that occur behind-the-scenes, Maryland should pursue creation of an integrated client relationship management and documentation system across health programs. It will be far easier for eligibility workers and others to help clients efficiently if they can readily see what already has been done on their behalf and the current status of their efforts to secure Medicaid or Marketplace coverage. (As discussed above, currently the MHBE service center staff use a different CRM system than local health departments, local departments of social services and Navigators). Similarly, as a

number of other states are now doing, Maryland should create a shared data repository and system for storing documentation of income and other components of eligibility that can be used by DHR, DHMH, and the MHBE. Indeed, one key function of MD THINK would be to reduce the need for duplicate verification by clients of their eligibility for means-tested programs across the health and social service domains.

## *Conclusion*

Maryland has established a strong forward path from which to continue to improve health and social service programs. It, however, is clear that more could be done to improve the entry points in Maryland, creating a more efficient and consumer-friendly way to enroll people in coverage and social service programs. The work ahead will need to include a continued focus on cross-agency collaboration that puts consumers at the center of the agenda; new approaches to staffing and using eligibility workers, service center staff, and the myriad of other organizations and individuals who assist with helping people to enroll in health and social service programs; a strong focus on reliable, usable data; and ensuring that IT systems support and facilitate streamlining and improved customer service. As they proceed, Maryland policymakers will need to be mindful of the potential for shifts in the federal government's willingness to finance eligibility and enrollment systems and other changes given the priorities of the new Trump Administration and Congress. Even so, Maryland should be able to continue to make significant strides in efficiently providing consumers with access to health and social service programs in the years ahead drawing on best practices from other states and its own rich history and experience.

# Appendices

## APPENDIX A: Report Methodology

### *Literature Review*

To inform development of the report, the research team conducted a review of the grey literature documenting state best practices for organizing entry points to health coverage and social service programs, and used this analysis to assess Maryland's current infrastructure and develop recommendations for related improvements. A list of notable resources identified during the literature review is available at Appendix C.

### *Data Collection to Inform Maryland Entry Points Inventory*

In developing the inventory of current Maryland entry points, the research team used publicly available information to develop an initial catalog of health and social service programs in Maryland and eligibility determination entry points for each. To supplement this review and in consultation with relevant state agencies, including the Maryland Department of Health and Mental Hygiene (DHMH), the Maryland Health Benefit Exchange (MHBE) and the Maryland Department of Human Resources (DHR), we designed a set of data collection tools aimed at capturing key qualitative and quantitative information on the organization of program entry points in the State. This included a:

**1. Qualitative Information Request Form** requesting descriptions of the entry points that Maryland residents can use to apply for and enroll in health coverage and other social service programs. Specifically, the form requested information on:

- The entry points available to individuals seeking enrollment in health and social service programs;
- The specific processes, staff and IT systems associated with each type of entry point, including those used to support the:
  - Application Process
  - Eligibility Verification and Determination Process
  - Process for Effectuating Program Enrollment
  - Renewal Process
  - Outreach and Engagement Strategies;
- Mechanisms used for cross-agency coordination to facilitate referral and enrollment in health or social service programs administered by sister agencies or other relevant entities.

**2. Quantitative Data Information Request Form** requesting data on Medicaid and Marketplace coverage applications (e.g., the number of applications received by and pending before the agency; number of enrollments, reenrollments and disenrollments in

related programs). The form included a Data Dictionary containing specifications for each of the data elements requested.

**3. Budget and Staffing Information Request Form** requesting relevant budget and staffing information including:
- The number of personnel directly involved in enrollment or reenrollment activities;
- Funding to support those personnel, as well as funding to support IT systems and other non-personnel expenses required for enrollment or reenrollment activities.

Data collection tools were distributed to relevant state agencies for review and completion, including to the DHMH, MHBE, DHR, Maryland Department of Aging (MDOA), Maryland Department of Juvenile Services (DJS).[28] To ease the administrative burden on agencies completing the request and ensure a comprehensive understanding of entry point processes, we also conducted in-person or telephonic interviews with participating agencies to discuss in detail entry point processes, staffing structures and IT systems.

### *"Best Practices" State Selection*

In developing the state best practices assessment, we worked to identify states that have implemented consumer-friendly, efficient, and/or cost-effective entry point systems and processes that facilitate improved access for consumers. The state best practice examples included herein, which are not exhaustive, are culled from a review of public documents and interviews with state officials.

Specifically, we conducted a literature review of state best practices for program alignment and integration, including to identify state innovators in this space. We also sought out states that have participated in state learning collaboratives or other efforts related to facilitating better alignment of health and social services, including the Urban Institute's Work Support Strategies (WSS) initiative which provided funding and technical assistance to support six states in their efforts to reform and align the systems delivering health and social services to low income individuals.[29] Ultimately, the four states highlighted here – Colorado, Idaho, New York, and Michigan – were selected based on the following criteria:

- *Creation of an efficient, streamlined eligibility determination process* for health coverage programs and experience addressing the integration of healthcare and social service programs and enrollment procedures;

- *Similarities to Maryland's healthcare landscape*, such as use of a State-based Marketplace, county-based organization of some or all eligibility and enrollment services, overlapping or joint administrative responsibility for health and social service programs across multiple state agencies, and similar populations; and

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[28] The research team also consulted with the Maryland State Department of Education (MSDE) and determined that it does not serve as a direct entry point for health coverage programs; thus, MSDE is not included in this report.

[29] http://www.urban.org/work-support-strategies

- *Recommendations from key state agencies in Maryland,* including DHMH, MHBE and DHR*, regarding states that have adopted approaches they wished to understand in greater depth. Where feasible, we attempted to incorporate these suggestions into our selection process.

Once selected, we facilitated interviews with relevant agency leadership from each of the selected states. Information collected during these interviews and gleaned from the literature review informed our development of potential options for the State's consideration to improve the organization of entry points in Maryland. Individuals interviewed included:


**Colorado**

Samantha O'Neill-Dunbar

*Legislative & Policy Analyst*

Colorado Department of Human Services


**Idaho**

Lori Wolff

*Administrator*

Idaho Department of Health and Welfare


Greg Kunz

*Deputy Administrator, Welfare and Self Reliance Services Division*

Idaho Department of Health and Welfare


**New York**

Judith Arnold

*Director, Division of Eligibility and Marketplace Integration*

New York State Department of Health


**Michigan**

Erin Emerson

*Chief of Staff, Medicaid Director's Office*

Michigan Department of Health and Human Services

# APPENDIX B: Role of Maryland Agencies in Eligibility Determinations for Health and Social Service Programs

| | Responsibilities for Eligibility Determinations | Key Resources | IT System | Expenditures on Eligibility and Enrollment – Health and Social Service Programs, FFY 2016 |
|---|---|---|---|---|
| **MHBE** | <ul><li>MAGI Medicaid</li><li>Marketplace (QHPs and related insurance affordability programs)</li><li>Maryland Children's Health Program (MCHP)</li></ul> | <ul><li>Maryland Health Connection (MHC) web application</li><li>Consumer Support Center (CSC)</li><li>Navigators</li><li>Certified Application Counselors</li><li>MHC mobile app</li></ul> | <ul><li>Maryland Health Benefits Exchange (MHBX)</li></ul> | $40.6 million<ul><li>$37.0 million – Medicaid</li><li>$5.9 million - QHP</li><li>$3.7 million - CHIP</li></ul> |
| **DHR** | <ul><li>Most Non-MAGI Medicaid categories (e.g., seniors, people with disabilities)[1]</li><li>Social service programs[2]</li></ul> | <ul><li>myDHR web application</li><li>Local department of social services workers</li><li>Community-based organizations and other partners</li></ul> | <ul><li>CARES</li><li>Children's Electronic Social Services Information Exchange system (CHESSIE)</li><li>Child Support Enforcement System (CSES)</li></ul> | $153.7 million[3,4]<ul><li>$121.0 million – social service programs[5]</li><li>$51.2 million – Medicaid</li><li>$3.9 million – CHIP</li></ul> |
| **DHMH** | <ul><li>Delegates MAGI to MHBE and selected non-MAGI to DHR</li><li>Retains eligibility determinations for waiver programs and limited number of other non-MAGI categories[6]</li></ul> | <ul><li>Local health department workers</li><li>Eligibility Determination Division (EDD) Workers</li></ul> | | $19.8 million[7]<ul><li>$18.5 million - Medicaid</li><li>$1.3 million - CHIP</li></ul> |

[1] Aged, Blind and Disabled (ABD); Qualified Medicare Beneficiary (QMB); Specified Low-Income Medicare Beneficiary (SLMB); Supplemental Security Income Medical Assistance (SSI-MA); Department of Juvenile Justice Medical Assistance (DJJ-MA); Foster Care Medical Assistance; Long-term Care Medical Assistance (LTC-MA)

[2] Food Supplement Program (FSP), Temporary Cash Assistance/Welfare Avoidance Grants (TCA/WAG), Emergency Assistance, Burial Assistance, Public Assistance to Adults; and, select other social service programs

[3] Caseload blend estimated for 2016 based on a random moment sample of local department of social services (LDSS) Family Investment Administration workers. Figures also include local department of social service workers, out-stationed eligibility specialists and central program and systems staff.

[4] Includes administrative support: Medicaid – $22.4 million; CHIP - $1.0 million.

[5] Includes SNAP, Child Support, Child Care, TANF and other state programs

[6] Includes home and community-based services (HCBS) waiver program; Money Follows the Person demonstration; Women's Breast and Cervical Cancer Initiative; and, Family Planning Program

[7] $14 million – local health department eligibility workers; $5.8 million – headquarters eligibility workers

Note: Budget figures may not add up due to rounding.

Sources:

"Enhanced Funding for Medicaid Eligibility Systems Operations Advanced Planning Document (OAPD) for FFY 2016" Maryland Department of Health and Mental Hygiene. August 2015.

Data Collection Tool

# APPENDIX C: References

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